Los Angeles County Department of Health Services
Maternal, Child, and Adolescent Health Programs
5 Year Plan Needs Assessment Report
2005 – 2009

I. SUMMARY/EXECUTIVE REPORT

From September 2003 to March 2004, Los Angeles County Maternal, Child & Adolescent Health Programs (MCAH) convened seven meetings of a community stakeholder Planning Group to conduct a maternal and child health needs assessment for the county. The Planning Group consisted of representatives from diverse organizations—ranging from community-based organizations to universities to other governmental entities. The group was responsible for developing a list of potential health issues, creating prioritization criteria, analyzing data on potential health issues, and prioritizing top issues. MCAH staff followed a similar process and the two processes were merged at the end to come up with the top priorities for the MCAH 5 Year Plan.

The final list of prioritized health issues intentionally included at least one issue in the three population groups served by MCAH: women and infants; children; and adolescents. The final four prioritized health issues are:

- Women & Infants: Improve birth outcomes (low birthweight, high birthweight, prematurity)
- Children: Reduce asthma
- Children and Adolescents: Reduce overweight
- Adolescents: Promote the health and well-being of adolescents

II. DESCRIPTION OF THE MCAH COMMUNITY HEALTH ASSESSMENT PROCESS

A. Planning Group Recruitment

Recruitment of Planning Group members began in the summer of 2003, with staff brainstorming a list of organizations that would be important to the success of the planning process. These included community-based organizations with expertise in maternal and child health, adolescent health, housing, environmental health, and substance abuse, as well as school districts, foundations, and universities. Governmental entities that participated included representatives from other Los Angeles County Department of Health Services programs, including the Office of Women's Health, Area Health Officers, Personal Health/County USC hospital and from other LA County Departments such as Children and Family Services and the Children's Planning Council. A representative from the Long Beach Health Department also served on the Planning Group. In the end, 40 people, including five MCAH staff, joined the Planning Group (see Appendix A).

Invitations to representatives from these stakeholder organizations described the proposed planning process including the purpose of the plan, the importance of their participation, and the commitment of time involved. The invitation also explained that the planning process would entail several distinct phases. During Phase I, a Planning Group would prioritize the key health issues for MCAH to address in the next 5 years. During Phase II, recommendations for strategies to address those needs would be developed, with input from community meetings, focus groups, and workgroups.

B. Describe how Partnerships were Used/How Community Input was Obtained

Partnership, collaboration, and community input were essential components throughout the entire needs assessment process. As explained in the description of the planning process below, community partners provided feedback on the process for developing the plan; developed the list of indicators from which prioritized needs would be chosen; developed criteria and rating scales for the selection of prioritized needs; analyzed and discussed data, discussed best practices; and finally, rated the issues to come up with the final list of prioritized needs. In the next phase of the planning process, MCAH will obtain broader community input by soliciting opinions from community members on the best strategies to address the top needs identified in the needs assessment. To do this, MCAH will hold community meetings with representatives from community-based agencies and organizations, as well as focus groups with clients.

C. Describe the Planning Processes

Preparatory Work

Before the first Planning Group meeting, staff identified a list of 70 potential health indicators to be considered by the Planning Group. In order to compile the list, staff researched other counties' 5 Year Plans and selected indicators relevant to MCAH health problems in LA County; in addition, the list included the 27 State-required indicators. Staff also prepared notebooks for Planning Group members with background information such as the MCAH vision; mission; overview of programs and objectives; headline performance measures; accomplishments-to-date on the last 5 Year Plan; and feedback from staff and community stakeholders involved in the development of the previous plan.

Feedback on the Process

Planning Group meetings began in September 2003. At the first Planning Group meeting, staff requested feedback on the proposed planning process, and suggestions included looking at the "big picture" and considering the role that MCAH can play in impacting broad determinants of health such as poverty, unemployment, and discrimination. As a result, staff added two additional meetings to the originally scheduled five to accommodate this request. At subsequent meetings, Planning Group members participated in small group discussions on the broad societal issues impacting the health of MCAH populations and the possible roles that MCAH could play in addressing these issues.

Development of Indicators

During the first several meetings, Planning Group members brainstormed potential sources of data for the list of indicators and added to and deleted from the original list compiled by staff. Criteria for determining whether to keep or delete an indicator included whether county-wide data was available for the indicator and whether the problem was severe or affected large

numbers of people. For example, Planning Group members added the prevalence of adolescent depression to the list because it is so widely prevalent, but deleted pediatric AIDS cases because this indicator, though severe, impacts relatively few individuals.

Development of Prioritization Criteria and Rating Scales

In the third and fourth meetings, Planning Group members selected criteria for prioritizing health problems and created rating scales for the selected criteria. Staff initiated this discussion by providing sample criteria, sample rating scales, and a sample issue prioritization form. Staff also explained that DHS was mandating the inclusion of one criterion, burden of disease, which would be ranked by a panel of experts in the field based on mortality and morbidity associated with each health issue. In addition to burden of disease, Planning Group members decided upon the following list of final criteria: 1) Are there disparities among subgroups? 2) Is the problem increasing? 3) Do best practices exist? 4) Has the community identified this issue as a need? Planning Group members then developed rating scales for each criterion.

Data Collection, Analysis, and Presentation

As the Planning Group discussed the list of potential indicators, the MCAH Research, Evaluation, and Planning (REP) Unit began to evaluate the adequacy of data sources for each indicator so that indicators could be deleted if data was not available. As indicators were finalized, the REP unit created data fact sheets for each indicator, presenting data in summary tables and graphs on prevalence; trends; and racial/ethnic and geographic disparities. Where possible, the fact sheets provided comparisons to Healthy People 2010 goals as well as rates for California and the United States. On the fact sheets, indicators were grouped by health issue; the issue of childhood asthma, for example, included indicators for asthma prevalence as well as hospitalization rates for asthma. The fact sheets were updated and revised as Planning Group members requested additional data.

Discussion of Data and Agreement on List of Health Issues

The fourth, fifth, and sixth meetings were dedicated to review and discussion of the data fact sheets. During these meetings, Planning Group members participated in small group discussions on one of three population groups, choosing between women and infants; children; and adolescents. MCAH staff facilitated these small group discussions and answered questions related to the data. In addition to data on their specific population, each small group was asked to review data on demographics and access to health care for the county as a whole. The purpose of the small group discussions was to identify the top 3 – 4 health issues for each specific population (i.e. women and infants; children; and adolescents) based on an assessment of disparities, trends, and prevalence. Each small group then presented their findings to the Planning Group as a whole, summarizing their data analysis for each issue. Based on these presentations, the Planning Group decided to narrow down the list of health issues under consideration to the top issues identified by each small group.

Non-Data Criteria

Two criteria selected by the Planning Group for the final ranking of health issues were unrelated to data. One of these was whether or not best practices exist – in other words, was there the potential to make a difference on a particular health issue? Rather than initiate another in-depth and time consuming data search related to best practices, MCAH asked Planning Group

members to stay in their small groups to discuss whether best practices exist for the top 3 – 4 health issues selected. Using their collective knowledge and the rating scales previously created, each small group recommended to the Planning Group how to score the best practices criterion. Planning Group members were free to accept or reject this recommendation during the final prioritization of issues. For the other non-data criteria selected by the Planning Group – has the community identified this issue as a need – Planning Group members were instructed to act as representatives of their own communities, scoring health issues based on their own perceptions of community concern.

Burden of Disease Panel

To rank burden of disease, MCAH staff recruited a group of nine obstetricians, pediatricians and epidemiologists from the community and DHS (see Appendix B) who participated in two teleconferences on this subject. Panelists were instructed to score each health issue based on the morbidity and mortality associated with that health problem, broken down into four components: prevalence, duration, disability, and mortality (each with its own rating scale). After calculating preliminary scores using an Excel spreadsheet, panelists participated in a group discussion about their scores and were allowed to change their individual scores based on this discussion, if desired. Final burden of disease ratings for each health issue were then calculated.

Participation of MCAH Staff

Because staff will be integrally involved in carrying out the 5 Year Plan, MCAH felt that it would be important to elicit their participation in the issues prioritization process. At a general staff meeting in February of 2004, MCAH staff participated in a process similar to that which the Planning Group was going through. Breaking down into small discussion groups focusing on one of the three populations (women and infants; children; and adolescents), staff reviewed the data fact sheets, selected 3 – 4 top issues per population, and reported their findings to the staff meeting as a whole. Staff that chose to participate then scored the top health issues using the four criteria selected by the Planning Group. All of the top issues identified by either the Planning Group or staff were included in the list of health issues to be scored.

Final Prioritization

The seventh and last Planning Group meeting in March of 2004 was dedicated to scoring the final list of health issues and discussing the outcome of the needs prioritization process. In preparation for the meeting, staff prepared an Excel spreadsheet that included scores from both the burden of disease panel as well as MCAH staff. As Planning Group members completed their rating of issues, their scores were data entered into the spreadsheet and merged with the burden of disease and staff scores so that the final ranking of health issues could be presented and discussed at the meeting. After scores were calculated and presented, Planning Group members discussed the outcome and provided MCAH with final feedback on the process. Before finalizing the list of prioritized issues, MCAH staff met with other County programs, e.g. Department of Mental Health, Alcohol and Drug Program, Office of Women's Health and Violence Prevention Program, to see if there were opportunities to partner to address some of the top issues. All of the program staff were enthusiastic about the prospect of collaborating with MCAH. Thus, MCAH will include program representatives in the strategy development phase to identify strategies that build on our respective programs' strengths and avoid any duplication of efforts.

III. MCH PLANNING MISSION STATEMENT AND GOALS

A. Description of process for developing the Mission and Goals

In 2003, MCAH was asked to submit mission and vision statements to the Public Health Quality Assurance unit. The following mission and vision statements have been approved:

> **Vision:** All women, infants, children, adolescent, and their families in Los Angeles County will thrive in a safe, healthy, and nurturing environment.
>
> **Mission:** To maximize the health and quality of life for all women, infants, children, and adolescents and their families in Los Angeles County.

Goals are developed yearly in conjunction with ongoing strategic planning activities. These will be developed in Phase II of the MCAH 5 Year Plan.

IV. MCH COMMUNITY ASSESSMENT

A. Community Health Profile

1. Geographic features

Los Angeles County is one of the nation's largest counties with 4,084 square miles, including the islands of San Clemente and Santa Catalina. It is bordered on the east by Orange and San Bernardino Counties, on the north by Kern County, and on the west by Ventura County and the Pacific Ocean. The primary mountain ranges are the Santa Monica Mountains and the San Gabriel Mountains. Its coastline is 81 miles long.

Approximately 99% of the county's population live in an urban setting.[1] However, the area varies geographically. The northern portion of the county, covered by desert and forest, is more rural. The rest of the area is primarily urban and suburban.

2. Population Demographics

2(a). Current population by age, gender and race

Los Angeles County, with a population of 9,733,697 as of 2001 (see Table 1), is the most populous county in California and in the entire United States. Approximately 28% of California's residents live in Los Angeles County. Between 1990 and 2000, the county's population grew 7.4%[2] and is projected to increase about 8% to 10,604,452 between 2000 and 2010. Women and men are represented almost equally; 49% of the population are men and 51% are women. In terms of a breakdown by age (see Table 2): 15.7% are children (ages 0-9), 15.4% are adolescents (ages 10-19), 61.6% are adults (ages 18-64), and 22.8% are women of reproductive age (ages 15 to 44). Female heads of household with children under 18 comprise 8.2% (257,611) of all households in the county.

[1] Health Data Summaries for California Counties, CA DHS, 1994.
[2] US Census 2000

About two thirds of the county's population is comprised of people of color (68%), with whites occupying the remaining third (31.7%) (see Table 1). By 2010, people of color will represent approximately 73% of the population[3]. Latinos comprise the largest ethnic group in the county, representing 45% of the total population. Whites (31%), Asians/Pacific Islanders (13%) and African Americans (10%) are the next most populous groups. American Indian/Native Alaskans (0.3%) and Native Hawaiian/other Pacific Islanders (0.3%) are also represented in the county. From 1990 to 2000, the percentage of whites and African Americans in the total population decreased: from 41% to 31% for whites and from 10.5% to 9.5% for African Americans. The percentage of the total population increased for both Asians/Pacific Islanders and Latinos: from 10% to 12% for Asians and from 37.8% to 44.6% for Latinos.

Table 1: Total Population in Los Angeles County (Year 2001)

	Number	Percent
Los Angeles County	9,733,697	--
African American	954,760	9.8%
American Indian & Native Alaskan	29016	0.3%
Asian/Pacific Islander	1,235,478	12.7%
Native Hawaiian & other Pacific Islander	13,886	0.3%
Latino	4,405,590	45.3%
White	3,083,249	31.7%

Sources of Data:
1. LA County, DHS, Data Collection & Analysis Unit
2. California State Department of Finance, "Race/Ethnic Population with Age and Sex Detail, 1970-2040", Sacramento, California, December 1998

Table 2: Population Percentages by Age Group (Year 2001)

Age Group (LA County)	Number	Percent
Infants (< Age 1)	146,312	1.5%
Children 1 to 4	587,323	6.0%
5 to 9	797,138	8.2%
1 to 9	1,384,461	14.2%
Adolescents 10 to 14	778,118	8.0%
15 to 19	718,965	7.4%
10 to 19	1,497,083	15.4%
Adults 18 to 64	5,998,946	61.6%
Women 15 to 44	2,221,422	22.8%
LA County Population	9,733,697	--

Source of Data:
LA County, DHS, Data Collection & Analysis Unit

[3] California State Department of Finance, "Race/Ethnic Population with Age and Sex Detail, 1970 – 2040", Sacramento, California, December 1998.

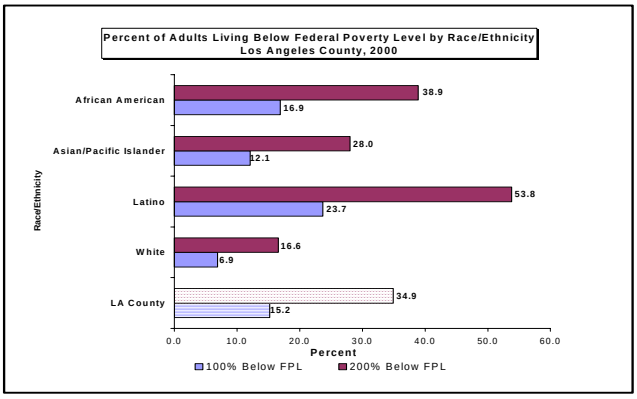
2(b). Language proficiency and percent foreign born

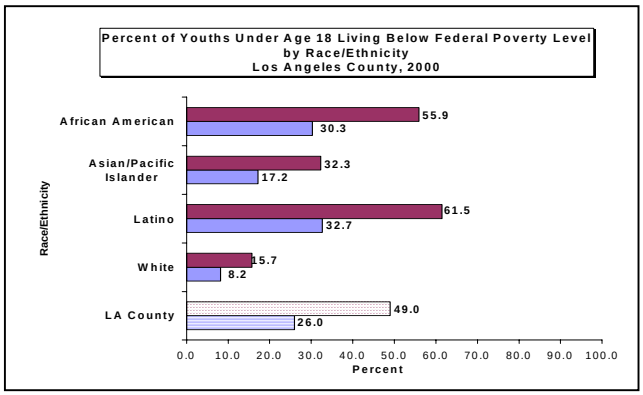
In 2000, 36.2% of Los Angeles County residents were foreign born. Of this group, the majority (62%) came from Latin America, almost a third (30%) came from Asia and the remaining immigrants came mainly from Europe and Africa. In 2002, more immigrants (108,614) arrived in Los Angeles County than in any other county in the state.[4] In terms of languages spoken, in 2000, 54% of Los Angeles County residents ages five and over spoke a language other than English at home, while 45% spoke English only. The three most common non-English languages spoken at home were Spanish (70%), Chinese (6%) and Tagolog (4.1%).

2(c). Economic Status

"Extremes of income characterize Los Angeles County, with rates of wealth and poverty higher than the state or nation…Increases in poverty and wealth suggest a trend toward a polarized society with a shrinking middle class."[5] Twenty three percent of households earn less than $20,000 and 3% have incomes of $200,000 or more.[6] Based on 1999 definitions of poverty using the Federal Poverty Level (FPL), "living in poverty" is defined as a family of two adults and two dependents with a total income of $16,895. In 2000, 15.2 % of adults in Los Angeles County were living in poverty and 26% of all children under age 18 were living in poverty (see Graph 1).

Graph 1: Poverty Rates for Adults and Children





Sources of Data:

1. LA County, DHS, Data Collection & Analysis Unit
2. U.S. Bureau of the Census, Census 2000

However, according to research conducted by the Los Angeles Alliance for a New Economy, due to the high cost of living in Los Angeles, a family of two adults and two dependents needs a minimum income of 200% FPL, or $33,790, to sustain itself.[7] Keeping in mind this alternate

[4] State of California, Department of Finance, *Legal Immigration to California in 2002.* Sacramento, California, October 2003

[5] United Way of Los Angeles County, "A Tale of Two Cities: Promise and Peril in Los Angeles," 1999.

[6] United Way of Los Angeles County, "A tale of Two Cities: Bridging the Gap Between Promise and Peril," 2003.

[7] Los Angeles Alliance for a New Economy, "The Other Los Angeles: The Working Poor in the City of the 21st Century," 2000.

definition of poverty at 200% FPL, in 2000, almost 35% of adults were living in poverty and 49% of all children under age 18 were living in poverty (see Graph 1). While jobs were added to the Los Angeles economy in the late 1990s, cutting the unemployment rate to 5% in 2000[8] many people who work are clearly not earning enough to support themselves and their families. Moreover, large disparities exist by race and geographic region. Latinos and African Americans have the highest poverty rates—53.8% of Latino adults and 38.9% of African American adults live in poverty (at 200% FPL) while 61.5% of Latino children and 55.9% of African American children under 18 years live in poverty (at 200% FPL--see Graph 1). SPAs 4 and 6 have much higher rates of adult and childhood poverty than the rest of the county.

As the region's population continues to grow, the shortage of housing looms as a serious problem. Home purchase and rental prices have increased substantially in the past years, making home ownership less viable, and forcing renters to pay an increasing share of their income on rent. In 2000, 52% of Los Angeles residents were renters. Twenty two percent of renters and 14% of homeowners paid more than 50% of their income for mortgage or rent payments. Further, 25.3% of all households living below 100% of the FPL were overcrowded.[9]

2(d) Educational status

Los Angeles County has fewer high school graduates than California or the U.S. In 2000, 69.9% of Los Angeles County residents ages 25 or over had completed high school, compared to 76.8% for California and 80.4% for the U.S. Mothers' level of education at the time of delivery reveals strong disparities by race and ethnity. While 94.2% of all white mothers and 92.7 of Asian/Pacific Islander mothers had completed 12 or more years of education at the time of delivery, the same is true for only 48.5% of Latino and 84.5% of African American mothers. Enrollment in public schools has increased 19% in the past decade, with a total of 1,465,595 students in the 1993-94 school year and a total of 1,742,960 students in the 2003-04 school year. This growth in school enrollment has been accompanied by an increase in the percentage of Latino students and a decrease in the percentage of white students.

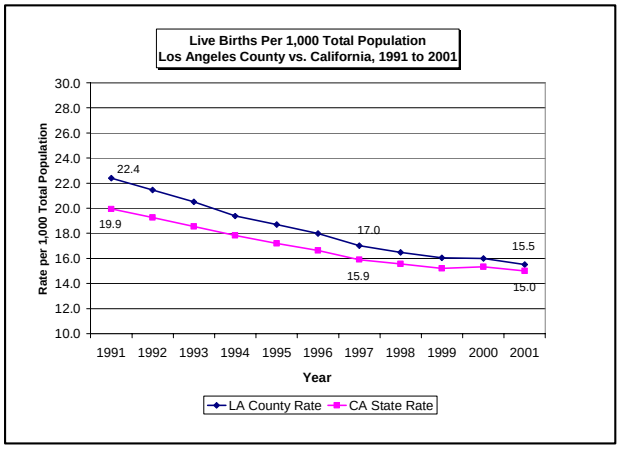
3. Selected Vital Statistics

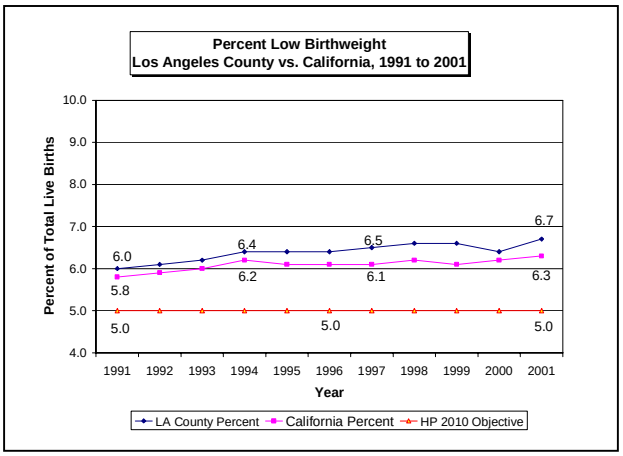
The rate of live births in Los Angeles decreased between 1991 and 2001, from 22.4 live births per 1,000 population to 15.5 ten years later (see Graph 2). Latinos have the highest birth rate at 22%, while the other ethnic groups' rates are much lower as seen in the following breakdown: African Americans (13%), Asians/Pacific Islanders (12%) and whites (9%). Geographic differences can also be seen, with SPAs 6 (22%.), 7 (17%) and 3 (17%) having the highest birth rates. In 2001, Los Angeles County recorded 153,524 live births with Medi-Cal paying for 50% of all deliveries. The infant mortality rate in 2001 was 5.4 deaths per 1,000 live births county-wide, with huge disparities by race/ethnicity, in spite of a continually improving county-wide trend that is approaching the Healthy People 2010 objective of <4.5. The percent of low birthweight births is on the rise from 6.0 in 1991 to 6.7 in 2001 (see Graph 2 below). Both the percent of low birthweight births and premature births is characterized by racial/ethnic disparities, with African Americans displaying the most severe rates.

[8] US Census 2000.

[9] US Bureau of the Census, "American Housing Survey for the Los Angeles-Long Beach Metropolitan Area, 1999, March 2001." Overcrowding is defined as 1.01 or more persons per room.

Graph 2: Live Birth Rate and Low Birthweight Rate: Trends





Sources of Data:

California Department of Health Services, Center for Health Statistics, Vital Statistics, 1991-2001
CDC, National Center for Health Statistics, "Births: Final Data for 2001", NVSR Volume 51, No. 2. 103 pp. (PHS) 2003-1120

4. Major heath issues facing the total community

Some of the biggest health problems facing the total community are: health coverage (especially for adults), food insecurity, and overweight/obesity. While much progress has been made to enroll children and adults in health insurance programs—primarily in Medi-Cal and Healthy Families—there are still 384,000 (13.6%) children under the ages of 18 who are uninsured and 1,312,000 (23%) adults without insurance.[10]

Additionally, food insecurity, defined as the limited or uncertain availability of nutritionally adequate and safe foods, has emerged as a serious issue in the County. Twenty two percent of lower income households (less than 300% FPL) experienced food insecurity (over 400,000 households) in 2002[11]. Children and adults experiencing food insecurity and hunger are generally in poorer health, with children also faring worse in school. Overweight and obesity is also on the rise for both adults and children. The percentage of adults who are obese increased from 14% in 1997 to 19% in 2002.[12] For children, 22% of 5th and 7th graders are obese and almost 16% of 9th graders suffer from obesity.[13]

A number of environmental health issues confront Los Angeles County residents. Air pollution is high in the county, and even higher in adjacent counties to the east. Air quality in the Los Angeles basin is among the poorest of any metropolitan area; on almost one in four days, state standards for air quality are not met in Los Angeles County. Further, over 80% of the county's housing units are at risk for lead poisoning due to construction dates that precede the legal

[10] Califonria Health Interview Survey (CHIS) 2001
[11] LA County Health Survey, 2002-03
[12] LA County Health Survey, 2002-03
[13] California State Department of Education, California Physical Fitness Testing Program, 2001.

elimination of lead from paint in 1978. Industry and other forms of toxic emissions are disproportionately located in lower-income communities, placing residents at a higher risk for health problems.

Not surprisingly, given the poor quality of air in Los Angeles County, asthma is a significant public health problem. Research has demonstrated a link between air quality and the severity of symptoms among those with asthma. An estimated 7.9% of children 0 – 17 currently have asthma. The actual prevalence may be far higher, as children with unrecognized asthma are not included in this estimate. The prevalence of asthma among African American children in the county (16%) is much higher than for African American children nationally (6.8%) and is also much higher than white, Asian/Pacific Islander and Latino children in the County (with rates of 9%, 9%, and 6% respectively). Indoor air quality also affects asthma. Approximately 7% of children in the county are exposed to tobacco smoke in the home on a regular basis; research indicates that among children with asthma, those exposed to tobacco smoke in the home are more likely to have asthma symptoms that limit their physical activity than those not exposed.

5. Political issues that may result in policy or funding changes affecting health

California's budget crisis, along with Los Angeles County Department of Health Services own fiscal woes, pose potential threats to funding and access to services. While the most recent version of the State's budget rescinds previously proposed cuts to Healthy Families and the Medi-Cal reimbursement rate, it remains to be seen how the maternal and child populations will be affected by the final budget and the state's ongoing financial struggles.

6. Community Health Profile Summary

- Los Angeles County's population is the largest of any county in the state and continues to grow.
- The diversity of residents is extensive. People of color comprise 68% of the total population and a majority of people (54%) speak a language other than English at home.
- There is a growing divide between rich and poor. According to the Los Angeles Alliance for a New Economy, a family with two adults and two children needs to earn 200% of the Federal Poverty Level (FPL) to support itself. Based on data from 2000, 40% of adults live in poverty and 49% of children under 18 live in poverty (i.e. at 200% FPL). At the same time, 3% of households have incomes of $200,000 or more.
- In 2001, Los Angeles County recorded 153,524 live births, with Medi-Cal paying for 50% of all deliveries. The birth rate decreased between 1991 and 2001 from 22.4 per 1,000 population to 15.5. Approximately 62.1% of live births in the county are to Latinos.
- Low birthweight births are on the rise, and significant racial/ethnic disparities exist for both prematurity and low birth weight.

B. Community Resources Assessment

Los Angeles County is an enormous metropolitan region serving a multitude of diverse communities with wide ranging health needs. Attempting to map assets or create a community resources assessment for the entire region would result in a compendium of general and only questionably helpful information. Instead, we decided that it would be more useful to tailor our community resources assessment around the top health needs prioritized by the Planning Group. Therefore, this assessment will identify concerns regarding access to care, shortages of providers, and gaps in service for the specific issues MCAH will address in the next five years (healthy births, asthma, obesity, and healthy adolescents) rather than for the county as a whole.

While health coverage was prioritized by the Planning Group as a top issue for women, infants, and children, MCAH has chosen to address it as integral to the other health issues facing these populations; in other words, we will address health coverage and access to care as they relate to improving birth outcomes, asthma, and obesity. We provide here an overview of health insurance and access to care as an introduction to these issues in the county.

Health coverage and access to care (women, infants, and children)
MCAH is a founding partner of the Children's Health Initiative – a public-private partnership consisting of foundations, health plans, providers, county agencies, and other organizations dedicated to providing universal health coverage for all children and youth in Los Angeles County. Data show that nearly 86% of children 0 – 18 in the county are enrolled in some form of health coverage[14]. While universal eligibility for children is currently a reality in LA County, long-term funding for such coverage has not been indefinitely secured and policy work to ensure that universal coverage becomes part of the political landscape is needed.

The Los Angeles County Department of Health Services, via funding through First 5 LA, contracts with community based agencies to provide outreach, enrollment, utilization and retention assistance to children and their families. Reaching the "eligible but unenrolled" population entails addressing the barriers that may keep families from accessing health services. These include concerns about "public charge"—or fear that using public benefits could negatively impact the immigration status of one or more family members; concerns about paying for health coverage when it is not really "needed", as well as other barriers. In addition, contracted agencies also provide assistance with utilization of services once clients are enrolled, emphasizing the importance of preventive care and assisting families with learning how to access the confusing patchwork of health care services and bridge successfully between programs. Helping families to reenroll in health coverage when they receive their renewal paperwork is also critical so that families maintain coverage over time.

Assisting families with gaining access to care is crucial; accessing primary care can assist families in managing care for children with chronic illnesses such as asthma and diabetes. Los Angeles County faces a shortage of providers that accept Medi-Cal; a problem that is greatly exacerbated by low provider reimbursement rates. Having insufficient Medi-Cal providers in the County restricts access to care for Medi-Cal recipients and can severely limit patient choice of providers.

[14] California Health Interview Survey (CHIS), 2001

Healthy births (women and infants)

Concerns regarding access to health care: Evidence-based clinical guidelines indicate that all pregnant women should be screened for tobacco and substance use, domestic violence, maternal depression, poor nutrition etc. However, in practice these guidelines are often not followed. According to one national survey, approximately one third of U.S. women giving birth reported receiving no advice on tobacco or other substance use from their prenatal care providers[15]. Barriers to implementing widespread screening include a shortage of treatment resources once needs are identified. For example, LA County has a serious shortage of residential substance abuse treatment programs where women can bring their children, a serious barrier to women seeking treatment.

Concerns regarding access to care also include diminishing resources for programs serving pregnant women; in the recent period, funding has been lost or severely reduced for three important County programs serving this population. The Nurse Family Partnership is a nurse home visitation program providing intensive home visitation services to young, first-time, low-income pregnant teens and women beginning in pregnancy and continuing through the child's second birthday. Demonstrated to be effective in national scientifically-controlled studies, Los Angeles County data demonstrate that the program has significantly improved both prematurity rates and low birth weight rates among women at high risk for poor birth outcomes. The program is currently operating at minimal capacity while additional funds are sought. Funding for the County's Prenatal Care Guidance program has also recently been reduced; this program identifies high-risk pregnant women and assures their access to appropriate prenatal care, increasing care coordination, referrals, and follow-up. Finally, the Perinatal Outreach and Education project provided outreach, health education, and case management services to low income pregnant women and women of childbearing age until all project funding was lost in 2003.

Gaps and needs include:

- Prenatal care quality improvement, including screening women for tobacco and substance use, domestic violence, depression, stress, poor nutrition etc, as per established evidence-based clinical guidelines.
- Ensuring that providers participating in the Comprehensive Perinatal Services Program, provide the full range of health education, nutritional counseling, and psychosocial assessment mandated by the CPSP program.
- Developing monitoring systems to measure quality of care provided by Medi-Cal providers; currently, very little data on quality of care is available.
- Increasing the number of Medi-Cal Managed Care (MMC) enrollees receiving CPSP services through their OB care provider. All MMC contracting health plans are required to ensure that their pregnant members have access to CPSP services, but it is unclear whether this is actually happening.
- Working to change Medi-Cal policy so that it promotes continuity of care throughout the perinatal period. Los Angeles County has many "family medical clinics" staffed by

[15] Kogan MD, Alexander GR, Kotelchuck M, Nagey DA, Jack BW. Comparing mothers' reports on the content of prenatal care received with recommended national guidelines for care. Public Health Reports 1994;109:637-46.

midlevel practitioners and general practice physicians that provide a portion of prenatal care and then transfer the patient to an obstetrician for the remaining prenatal care and delivery. This fragmented care results in missed diagnoses, such as gestational diabetes, as well as higher costs due to duplicate services.

- Assessing access to the obstetrical provider network in Los Angeles County by Service Planning Area and identifying those areas with shortages of obstetricians for routine and high risk care.
- Improving the network of provider referrals so that adequate resources are available when providers identify women in need of assistance; for example, increase the number of residential substance abuse treatment programs that serve women with children.
- Grassroots policy and advocacy initiatives promoting healthy births, including local efforts such as making workplaces more family friendly, as well as efforts to impact federal and state legislative decisions.
- Health education and messaging to pregnant and parenting women, families, and communities, such as the campaign promoting the use of folic acid among women of childbearing years.
- Outreach to and case management for pregnant women to identify women at high risk of poor birth outcomes; assess areas where intervention is indicated; provide referral resources and social support; and assist with service coordination.
- Promoting preconception care to optimize women's health status and address complex issues such as partner violence and substance use before women get pregnant; increasing access to affordable health care for all women of reproductive age so that pregnancy-related care can begin prior to conception.
- Promoting social support for pregnant women by increasing partner, family, and community support through male involvement programs, family resource centers, etc.
- Training pediatricians and other early childhood specialists to use a "family-based approach" during well-child visits, including assessing mothers for depression and referring them to appropriate psychosocial support resources as needed.

Asthma (children)

Concerns regarding access to health care:
While little is known about how to prevent asthma, much can be done to prevent asthma-related symptoms. Therefore, access to high quality health care services is extremely important for children with asthma. If children do not have adequate preventive care and treatment, many will end up in emergency rooms; LA Health Survey data show that 60 percent of asthmatic children younger than 5 had to visit an emergency room in the past 12 months for their asthma[16]. Improving access to medical care and other support services such as psychosocial support, asthma education and instruction on use of inhalers and other asthma medications is key. Whenever possible, these services should be provided by or closely linked to the child's "medical home" – that is, a primary care provider who can ensure continuity of care and optimal disease management.

[16] LA Health County Health Survey, 1999-2000

Gaps and needs include:

- Asthma education programs for providers that emphasize treating asthma as a chronic disease that is best managed using a written asthma management plan and other user-friendly tools that can facilitate appropriate asthma care, education, and communication with asthma patients. Providers also need information about treatment specialists in their area so that they can refer patients when necessary.
- Asthma education among parents to increase understanding that asthma is controllable, to teach methods for controlling it, and to stress the importance of reducing exposure to environmental triggers.
- Asthma education for other adults having contact with children such as teachers, school administrators, nurses, and coaches so that they are aware of effective asthma management and the importance of having children's asthma management plan and asthma medications readily available at school.
- Development of clinical guidelines for the care of asthmatic children, along with measures of health plan and physician performance.
- Revision of Medi-Cal reimbursement regulations so that Medi-Cal will pay for more than one inhaler (one for home use and one to keep at school).
- Regulatory action to reduce traffic-related air pollution such as reducing/eliminating emissions in new vehicles, retrofitting school buses and diesel trucks; investing in public transport; encouraging carpooling, building bicycling and walking paths, etc.
- Reduction in children's exposure to traffic-related air pollution by filtering air in schools; limiting vehicles near schools and separating schools from roadways; reducing outdoor activity when pollution is high etc.

Obesity (children and adolescents)

Concerns regarding access to health care:
As with asthma, access to high quality health care services is central to helping children, adolescents, and family members maintain a healthy weight. However, an important area of concern is that health coverage plans do not cover the *prevention* of overweight/obesity – instead, they reimburse providers only for the treatment of illnesses that result from overweight and obesity, such as diabetes or high cholesterol. In other words, providers cannot refer children to exercise and nutrition programs until children are actually diagnosed with a medical problem. A related concern is that there is currently a shortage of programs in LA County that work with children and families on diet, nutrition, and exercise.

Gaps and needs include:

- Increasing eligibility and participation in federal food programs (such as the food stamp program and school and community nutrition program), improving the enrollment process so that it is more consumer friendly.
- Promoting and improving access to a healthy breakfast for all children countywide, on school campuses, in childcare, and in summer programs.
- Banning the sale of soda and junk foods on elementary, middle and high school campuses; reinforcing the recent legislation banning the sale of soda at the elementary and middle school levels so that it is extended to include all schools and junk food as well as soda.

- Increasing the availability of fresh fruits and vegetables in low-income neighborhoods by encouraging grocery stores and corner stores to provide healthy, affordable, and nutritionally adequate food; making farmers' markets and community gardens more accessible; and improving public transportation between low-income communities and grocery stores.
- Community-wide public awareness campaigns that encourage healthy eating and promote physical activity.
- Access to safe places for physical activity such as parks, bike paths, and recreational facilities, and point-of-decision prompts to increase physical activity.
- Policies that increase amount and quality of physical education in schools, including physical education teachers, space for physical education activities, and funding for physical education equipment.
- Development of joint/shared use of facilities among schools, parks, libraries, health care clinics, and community based organizations to increase opportunities for physical activity and healthy eating.
- Improving urban and transportation planning to emphasize land use policies that decrease time spent in cars and increase opportunities for walking and bicycling.
- Improving access to and availability of individual health behavior change programs such as KidShape, a non-profit program that works with children and families on diet, nutrition, and exercise.

Promote healthy adolescent development (adolescents)

Concerns regarding access to health care: The demand for alcohol and drug treatment services for youth in Los Angeles County far exceeds the current availability of resources to meet those needs – the need is currently about ten times the capacity of the current system and within specific populations (like the juvenile hall or child welfare systems) the need is even greater. Resources to increase capacity are limited, and although there is a clear need for additional programs, it is difficult politically to open new centers because of the "not in my backyard" syndrome – no one wants these centers in their area. There is also a shortage of qualified counselors that could staff additional facilities if funding and sites were available – for example, staff with expertise in counseling youth on both mental health issues and alcohol and drug abuse. Because there are such a limited number of treatment services available, the programs that do exist must continually balance the number of individuals identified as needing services against the number of places available to treat them.

Addressing access to care among adolescents entails more than an assessment of the services that are not currently available. The issues facing youth in LA County are part and parcel of the environment in which they are growing up: over a quarter of LA County children under age 18 live below the federal poverty level. Among children of color, the rates rise to well over half, with 62% of Latinos and 56% of African American children living in poverty. Poverty, along with other social factors such as racism, sexism, and unemployment, creates hopelessness in young people, and a sense that few life options exist. In such an environment, supporting youth development and access to services should focus not on identifying problems among young people, but on attempting to understand and promote the successes that have allowed young people to thrive in difficult environments. Called the resiliency model, this approach attempts to

identify and promote the strengths, resources, and assets of individuals and communities that would otherwise be at risk for adverse outcomes.

Gaps and needs include:

- Increasing the number of alcohol and drug treatment residential and outpatient services for youth, and increase the number of trained counselors capable of addressing mental health issues among youth.
- Increasing the availability of prevention services; current efforts do not reach many areas of the county.
- Conducting countywide media and health education campaigns, such as media messages about the dangers of alcohol abuse. LA County Health Survey data indicate that 88% of drinkers and 87% of non-drinkers favor increasing the use of such public services messages[17].
- Supporting policy efforts such as working with the media to promote the depiction of responsible behaviors on the part of young people and changing the target audience of alcohol advertising.
- Increasing availability of services for adolescents offered in accessible and convenient locations such as school based clinics, family planning clinics, and community-based centers
- Increasing the number of providers participating in Family PACT (California's Family Planning, Access, Care and Treatment program), whose goal is to broaden access to family planning services for low-income adolescents by expanding the network of providers available to them.
- Encouraging providers to adopt nationally recognized professional guidelines for adolescent health care; models for effective adolescent programs include programs such as youth development, peer educator, and male involvement strategies.
- Promoting viable alternatives to substance use and gang involvement by offering job training, skills building, and other types of youth development.
- Promoting mentoring programs that allow youth to develop extrafamilial adult relationships, including adult relatives, friends' parents, teachers, or mentors.
- Supporting programs that allow youth to develop self-confidence and self-esteem, such as volunteerism, apprenticeships, or extracurricular activities.

C. Review of the State Required Indicators

MCAH staff prepared a draft list of potential indicators for the Planning Group. This list contained the 27 State-required indicators, as well as additional indicators. To arrive at these additional indicators, MCAH staff researched other counties' MCH 5 Year Plans to see what indicators other counties included in their planning efforts.

The Planning Group was asked to add to or delete from the list of potential indicators. Once the final list of indicators was selected, MCAH staff collected data for the indicators. To present the data in as clear and understandable a fashion as possible for the Planning Group, the MCAH staff created "fact sheets" (see Appendix C) which present graphs as well as comparison and disparity data, including Healthy People 2010 objectives, California and US rates, breakdowns by race/ethnicity and by region or Service Planning Area (SPA). The fact sheets provided key

[17] LA County Health Survey, 2002-03

quantitative information to Planning Group members to facilitate their analysis of data. We include data from these fact sheets in this section, when specified. All other data presented in this section is from the State's templates (see Appendix D). (Note: The column on the State's templates which shows the State versus the County ratio may not apply to the County of Los Angeles because the county represents 1/3 of the state's population).

The Planning Group took a "hands-on" approach to data analysis, dedicating three of its seven meetings to reviewing and discussing the data fact sheets. After analyzing the data collected, the Planning Group narrowed down the list of indicators to the smaller list described here and in the "Optional Topics" sections. This narrowing down of potential needs was the first step in the prioritization process.

1. WOMEN & INFANTS

A. Birth Outcomes

Percent Low Birth Weight
Definition: The percent of live born infants weighing less than 2,500 grams at birth
Los Angeles County (2001): 6.65% (events=10,213)
Healthy People 2010: 5%
State (2001): 6.29%
Trend: Increase from 6.02% in 1990 to 6.65% in 2001. Further, the rates are well above the Healthy People 2010 objective. The actual numbers are decreasing, from 12,283 in 1990 to 10,213 in 2001, due to a smaller number of total births.
Differences among subgroups: African Americans have the highest rate of low birthweight births (11.8%), almost double that of the other races/ethnicities. The different rates by SPAs are not as marked as those by race/ethnicity, but SPAs 1 and 6 have higher rates than the other SPAs at 7.3%. (See the attached LAC Data Fact Sheets; Section 3: Women & Infants 0-1).

Percent Preterm Births
Definition: Percent of births occurring at less than 37 weeks of gestation
Los Angeles County (2002) 10.1%:
Healthy People 2010: 7.6%
State: 9.8%
Trend: A decrease from 10.8% in 1998 to 10.1% in 2002. However, the rates are well above the Health People objective.
Differences among subgroups: In 2001, African Americans had the highest rate of premature births at 15.0%, compared to 10.2% for Latinos, the next highest rate, 9.5% for Asian/Pacific Islanders, and 9.2 for whites. SPAs 1 and 6 had the highest rates, at 13.2% and 11.7 % respectively (See the attached LAC Data Fact Sheets; Section 3: Women & Infants 0-1).

The infant mortality rate for LA County has declined significantly in the past 11 years, from 7.98 in 1990 to 5.39 in 2001, approaching the Healthy People objective of 4.5. However, the rate is marked by stark racial/ethnic and geographic disparities. The infant

mortality rate among African Americans (11.4 deaths) is twice as high as the rate for the county as a whole, and among African Americans in one geographic region – the Antelope Valley (SPA 1) – the rate is more than five times the county average (28.4 deaths). MCAH is currently working with a community coalition in SPA 1 to identify and address the causes for the disproportionately high infant mortality rate there—overall and for African Americans, in particular. Despite large disparities by race/ethnicity and SPA, the Planning Group decided not to include infant mortality as part of the prioritized "birth outcomes" category because of the improving trend for the county overall.

B. Health Coverage and Perinatal Care

Percent Prenatal Care in First Trimester

Definition: The percent of live born infants whose mothers received prenatal care in the first trimester of pregnancy
Los Angeles County (2001): 88.4%
Healthy People 2010: 90%
State: 85.4%
Trend: The percent of women who receive prenatal care in the first trimester of pregnancy has increased from 70.6% in 1990 to 88.4% in 2001.
Differences among subgroups: According to the attached LAC Data fact sheets (see Section 2: Health Coverage, p. 4 and 5), in 2001, whites had the highest percentage of first trimester onset of prenatal care (92.8), followed by Asian/Pacific Islanders (89.6%), Latinos (84.7%) and African Americans (83.2%). SPA 5 (91.9%) and SPA 2 (90%) had the highest rates of first trimester onset of prenatal care, while SPA 6 (80.9%) and SPA 1 (83.1%) had the lowest rates. Further, women in older age groups, ages 30 to 40 had higher rates of first trimester onset of prenatal care (89%) and adolescents ages 15 to 19 had the lowest rates of care (77.7%). Women without health insurance (77.8%) and women receiving Medi-Cal (82.3%) had the lowest rates of first trimester onset of prenatal care compared to women with private insurance (94.1%).

Proportion of Women with Adequate Prenatal Care (Kotelchuck Index)

Definition: The percent of live born infants whose mothers received adequate prenatal care as defined by the Adequacy of Prenatal Care Utilization (APNCU) Index developed by Milton Kotelchuck.
Los Angeles County (2001): 77.5%
Healthy People 2010: 90%
State: 74.2%
Trend: Increase in the adequacy of prenatal care from 58.3% in 1990 to 77.5% in 2001, though the percent is still far below the Healthy People objective of 90%.
Differences among subgroups: Whites (85.1%) and Asian/Pacific Islanders (80.7&) had the highest percentages of adequate prenatal care, while Latinos (73.5) and African Americans (72.8%) had lower percentages. (See *LAC Data fact sheets Section 2: Health Coverage, p. 8).*

C. Domestic Violence

Number of Domestic Violence Related Calls for Assistance in One Year

Definition: Number of domestic violence calls for assistance per 1,000 population
Los Angeles County (2002): 5.6 (events = 56,452)
Healthy People 2010: None
State: 5.5
Trend: n/a

Many women experience domestic violence but do not call the authorities for assistance. Therefore, this rate most likely underestimates the prevalence of domestic violence. Further, intimate partner violence increases when women are pregnant, underscoring the need to address this problem from a maternal health standpoint.

D. Breastfeeding

Percent of Women Who Were Breastfeeding at the Time of Hospital Discharge*

Definition: Percent of mothers who breastfed upon hospital discharge.
Los Angeles County (2001): 79%
Healthy People 2010: 75%
State: 83%
Trend: From 1994 to 1999, breastfeeding upon hospital discharge increased from 71% to 77%, a rate above the Healthy People 2010 objective.
Differences among subgroups: Differences by race/ethnicity exist with whites exhibiting the highest percentage (85%), followed by Latinos (79%), Asian/Pacific Islanders (75%) and African Americans (63%).

However, the data reveal mixed outcomes. While the percent of mothers who breastfed upon hospital discharge was high (79%), only 27.7% of women report that they intend to exclusively breastfeed upon hospital discharge (State-supplied data). This difference could be due to the fact that many of the women breastfeeding at hospital discharge were already feeding their infant food sources other than breast milk or that they planned to introduce formula after leaving the hospital, especially those women who plan to return to work shortly after giving birth. Further, the data on breastfeeding rates at six months after birth demonstrate a drop to 40%, below the Healthy People 2010 objective of 50% at six months after birth*. Disparities by race/ethnicity exist at 6 months after birth, with white mothers (50%) and Latino mothers (42%) breastfeeding more frequently than Asian/Pacific Islander (25%) and African American (22%) mothers.

**The data presented is from the LAC Data fact sheets Section 3: Women & Infants, p.13, 14, as the State-provided data for this indicator was introduced after this section was written.*

2. CHILDREN

A. Asthma

Prevalence*

Definition: Percent of children ages 0 to 17 ever diagnosed with an episode of asthma in the past 12 months
Los Angeles County (2000): 6.1%
Healthy People 2010: None
Trend: n/a
Differences among subgroups: African American children have the highest asthma prevalence at 16%, followed by white children at 7%, Asian/Pacific Islander children at 6% and Latino children at 4%. However, the apparently low rate for Latino children could be a gross underestimate since they have the highest rates of not having health insurance, and therefore many Latino children may never have been diagnosed with asthma due to a lack of health coverage.

Children ages 0 to 4 have the highest hospitalization rates for asthma, although the trend data from 1989 to 2000 shows the rates getting better. In 2000, 324 children ages 0 to 4 were hospitalized for asthma per 100,000 children, while 126 children ages 5 to 18 were hospitalized for asthma. The trend for the older group of children is about the same over this 11-year period.

**This prevalence data comes from the LAC Data fact sheets Section 2:Children, p.4*

B. Overweight/Obesity (see "Adolescent" section)

C. Health Coverage

Percent of Children and Adolescents without Health Insurance

Definition: Percent of children & adolescents (ages 0 to 19) without health insurance.
Los Angeles County (2001): 13.6%
Healthy People 2010: 0%
State: 10.5%
Trend: n/a
Differences among subgroups: Children ages 11 to 18 have higher rates of uninsured (19%) than children ages 1 to 10 (9.9%). Among children ages 1 to 10, Latinos have the highest rates of uninsured (15.8%); among children 11 to 18, Latino and Asian Pacific Islanders have the highest rates of uninsured with 28% and 16.3% respectively (see LAC Data fact sheets Section 2: Health Coverage, p. 1).

Los Angeles County has made great strides in the last two years in increasing access to health insurance for infants and children and is well positioned to continue making progress on this issue. In July 2003, with the financial support of the First 5 LA

Commission, the Healthy Kids Initiative began to provide coverage to young children 0 – 5 in families at or below 300% federal poverty level – effectively filling in the gaps for children ineligible for Healthy Families, Medi-Cal or other publicly funded health coverage. In May 2004 the Healthy Kids Initiative was expanded to provide coverage to children 6 – 18 as well; as a result, all children in the county are now eligible for free or low-cost health coverage.

Percent of Children without Dental Insurance

Definition: Percent of children (ages 2 to 11) without dental insurance.
Los Angeles County (2001): 25.9%
Healthy People 2010: None
State: 23.3%
Trend: n/a
Differences among subgroups: Latinos (30%) have the highest percentage of children ages 0 to 11 without dental insurance, followed by whites (22%), Asian/Pacific Islanders (21%) and African Americans (14%)—see LAC Data fact sheets Section 2: Health Coverage, p. 6).

Percent of Children Who Have Been to the Dentist in the Past Year

Definition: Percent of children (ages 2 to 11) who have been to the dentist in the past year.
Los Angeles County (2001): 73.5%
Healthy People 2010: None
State: 73.4%
Trend: n/a
Differences among subgroups: In terms of differences by race/ethnicity, African Americans, Asians/Pacific Islanders and whites all had similar rates ranging from 75% to 80%, while Latinos had a lower percentage of 68 %. Data was not available broken down by SPA.

3. ADOLESCENTS

A. Overweight/Obesity

Percent of Children and Adolescents Who Are Overweight*
a. Children
Definition for "overweight": BMI for 5th and 7th grade students at or above the 95th percentile based on growth charts from the CDC.
Definition for "at risk for overweight": BMI for 5th and 7th graders >=85th percentile &<95th percentile based on growth charts from the CDC.
Los Angeles County (2001): Overweight: 22.5%; At risk for overweight: 19.4%
Healthy People 2010: Overweight: 5%
State: n/a

Trend: n/a
Differences among subgroups: Latino children have the highest rate of overweight (27.4%), followed by African Americans (20.5%), Asian/Pacific Islanders (14.9) and whites (13.4%). The percentages for "at-risk" for overweight follow the same pattern, except that Asian/Pacific Islanders have a slightly higher percentage than whites. Data was not available broken down by SPA. The data on fruit and vegetable consumption also reveal disturbingly low rates, with African Americans and Asians/Pacific Islanders exhibiting the poorest rates. Similarly, the physical fitness rates among 5th and 7th graders are extremely low, with African American and Latino students demonstrating the lowest rates.

b. Adolescents
Definition for "overweight": BMI for 9th grade students at or above the 95th percentile based on growth charts from the CDC.
Definition for "at risk for overweight": BMI for 9th graders >=85th percentile &<95th percentile based on growth charts from the CDC.
Los Angeles County (2001): Overweight: 15.8%; At risk for overweight: 16.9%
Healthy People 2010: 5%
State: n/a
Trend: n/a
Differences among subgroups: Latino adolescents have the highest rates of overweight (and at-risk for overweight) at 19.3% (19.2%), followed by African Americans at 15% (17.4), whites at 11.7% (11.7%) and Asian/Pacific Islanders at 9.1% (12.9%). Data was not available broken down by SPA. The data on fruit and vegetable consumption and fitness rates for 9th graders illustrate similar patterns to those of 5th and 7th graders, except that Asian/Pacific Islander teens appear to be eating more fruits and vegetables than Asian/Pacific Islander children.

**This data is from the LAC Data fact sheets Section 3: Children, p.13, as the State-provided data for this indicator was limited.*

B. Mental Health

Rate of Adolescents Hospitalized for a Mental Health Reason

Definition: Number of teens ages 15 to 19 hospitalized for mental health reasons per 100,000 teens ages 15 to 19.
Los Angeles County (2000): 858.1 (events = 5, 450)
Healthy People 2010: None
State: 807.9
Trend: The trend illustrates an increase in the rate from 695.6 (events = 4,780) in 1989 to 858.1 in 2000 (events 5,450).

LA County also gathered additional data on adolescent mental health, which highlighted the severity of this issue. The additional data revealed that 34% of all adolescents report feeling "so sad and hopeless in the past 12 months that they stopped doing some usual

activities." This percentage holds steady for 9th graders through 12th graders. In addition, in 2003, 11.4% of teens attempted suicide one or more times. The percentages are highest for 9th and 10th graders who may be more at risk. The suicide death rate among 15 to 19 year olds in LA County is 4.3 per 100,000, with disparities by race/ethnicity: 5.4 for African Americans, 5.0 for Latinos, 3.6 for whites and 2.2 for Asian/Pacific Islanders (see the attached LAC Data fact sheets; Section 5: Adolescents).

C. Teen Birth Rate

Teen Birth Rate

Definition: The number of births in specified age groups per total number of females in specified age groups.

Los Angeles County (LAC) vs. California (2001):

Ages 10-14: .69 (n=269) vs. California: .61
Ages 15-17: 27.9 (n=5,373) vs. California: 24.4
Ages 18-19: 83.8 (n= 10,177) vs. California: .61

Healthy People 2010: None for these specified age groups.

Trend: The eleven-year trend from 1990 to 2001 demonstrates a decrease across all age groups. For ages 10-14, the drop is from 1.81 to .69 (516 births to 269 births); for ages 15-17, the decline is from 50.6 to 27.9; and for ages 18-19, the decrease is from 111.6 to 83.8.

Differences among subgroups: The Planning Group also examined data on the teen birth rate for ages 15-19. While the ten-year trend from 1990 to 2000 illustrates a drop from 77.3 to 53.7, disparities by race/ethnicity and by SPA exist. Latino and African American teens have significantly higher birth rates at 74.6 and 62.4, respectively, compared to 10.2 for Asian/Pacific Islanders and 14.3 for whites. SPA 6 has the highest teen birth rate at 83.9, with most of the other SPAs' rates ranging from 40 to 50, with the exception of SPA 5 at 16.7 (See the attached LAC Data fact sheets; Section 5: Adolescents).

Percent of Teen Births to Women Who Were Already Mothers*

Los Angeles County was able to obtain data for the Planning Group on the percent of births that were second or higher order birth (parity of two or above) to teen mothers ages 15 to 19 at the time of the birth. For the county as a whole, the rate was 21.3% in 2000, with Latinos (22.2%) and African Americans (19.4%) exhibiting higher rates than whites (16.2%) and Asian/Pacific Islanders (12.2%). SPAs 6, 7 and 4 had the highest rates at 22.7%, 22.8% and 22%, respectively, and SPA 5 had the lowest rate at 14.3%. The trend is slightly decreasing from 22.4% in 1995 to 21.3% in 2000 (see the attached LAC Data fact sheets;).

**This data is from the LAC Data fact sheets; Section 5: Adolescents*

Qualitative Data

The Planning Group examined the results of county-wide focus groups conducted by the Los Angeles Best Babies Collaborative, an initiative launched and funded by the Los Angeles First 5 Commission. These focus groups asked practitioners, health educators,

outreach works and other professionals in the maternal health sector to identify the top needs for pregnant women. The Planning Group took these results into consideration as part of the needs assessment, paying particular attention to the emergence of mental health, substance abuse and domestic violence as priority areas for impacting birth outcomes (and for which scant quantitative data are available countywide). The focus groups identified the following priority areas:

- Access to resources
- Access to care
- Mental health (screening for and referral to services)
- Psychosocial support
- Substance abuse (screening for and referral to services)
- Domestic violence (screening for and referral to services)
- Quality of care
- Cultural competence
- Nutrition/breastfeeding
- Pregnancy preparedness/preconception care/infant care
- Teen services

D. Optional Topics

The Planning Group introduced five optional topics that were selected as local problem areas. MCAH staff had mixed success gathering data on these issues. Below is an explanation of the topic and an overview of the data relating to each topic.

1. WOMEN & INFANTS

A. Mental Health/Behavioral Health

The MCAH needs assessment identified birth outcomes and mental/behavioral health – including substance abuse, depression, stress, and domestic violence – as top health issues among women and infants. Because mental and behavioral health issues have such a negative impact on birth outcomes, MCAH will address them as one interconnected issue. In addition to their impact on birth outcomes, mental and behavioral health issues are associated with significant morbidity and mortality for women. In Los Angeles County, alcohol dependence and depression are both leading conditions associated with disability adjusted life years – or DALYs – for women, a measure combining years lost due to premature mortality and years lived with a disability.

It was difficult to find data on maternal substance abuse locally, so the Planning Group examined data on substance use among all women in the County and statewide. In Los Angeles County, 14% of women ages 18 and over report that they drank five or more alcoholic drinks on a single occasion and 11% currently smoke cigarettes, with African American and white women displaying the highest smoking rates (20% and 17.6% respectively). No data is available on substance use during pregnancy, but statewide data demonstrate that 9.8% of women smoke during pregnancy.

While there is also a dearth of data on women's mental health, we found data illustrating that 8% of women ages 18 and over have seen a health professional for an emotional/mental health problem. White women have sought mental health assistance (12%) more than women of other races/ethnicities possibly because they have better access to health care professionals or because seeking mental health assistance is less stigmatized among the white population than among other racical/ethnic groups who sought assistance less frequently: African Americans (6.8%), Latinos (4.9%) and Asian/Pacific Islanders (3%). *(See Appendix C - LAC Data fact sheets; Section 3: Women & Infants 0-1).*

B. Environmental Toxins

Originally the Planning Group considered lead poisoning as a potential priority area for both the Women & Infants and Children populations. Toward the end of the data analysis discussions, the group expanded the issue to "environmental toxins" encompassing lead, mercury, pesticides, industrial chemicals and food additives, due to an increase in public discussion and awareness about the potential adverse affects of these toxins on birth outcomes and children's health. Until the State's data collection system is fully in place, as a result of SB 460, Los Angeles County is unable to estimate the prevalence of childhood lead poisoning. Current statistics from Los Angeles County's Childhood Lead Poisoning Prevention Program (CLPPP) reveal that over 13,000 children, primarily between the ages 0 to 6, have been diagnosed with elevated blood lead levels (>= 10ug/dl) from 1992 to 2002. Further, 80% of Los Angeles County's housing stock is at risk for producing lead exposure because it was built prior to the elimination of lead in paint in 1978.

Both LA County and the State have issued warnings in the past few years about the risk of pregnant women consuming fish known to contain high levels of mercury which can harm an unborn child's developing nervous system if eaten regularly. Governor Davis signed legislation before leaving office banning the use of certain flame retardants known to cause birth defects and accumulate in human breast milk. While there is still much to learn about the impact of exposure to various toxins on unborn children, nursing infants and children, there is growing concern about the need to address environmental toxins as a maternal and child health issue.

2. CHILDREN

A. Developmental Delays

Many Planning Group members were concerned about the need for early diagnosis of development delays in children. In 1999, 4.7% of children ages 0 to 5 in Los Angeles County were diagnosed with development delays (51,000 children). Only a little more than half—57%--subsequently received special services for their condition. Further, 14.7% of parents with children ages 0 to 5 are concerned about a possible developmental problem, indicating that many children may be undiagnosed for a developmental delay. *(See the attached LAC Data fact sheets; Section 4: Children).*

3. ADOLESCENTS

A. Violence and Substance Abuse

The MCAH needs assessment identified mental health, substance abuse, and violence as top needs for the adolescent population. Because these three issues are so interconnected, and because interventions that address one issue are likely to impact the others, MCAH will address them as one issue: promoting the health and well-being of adolescents. All three issues are associated with significant morbidity and mortality among adolescents. Depression among youth is pervasive in LA County, as discussed above. Many teens turn to alcohol and drugs as coping strategies: 22% of high school students report excessive alcohol use (5 or more drinks within a couple of hours on at least one day in the last month) and 17% report sniffing glue, aerosol spray, or paints to get high at least once in their life. Rather than alleviating depression, mental health consequences of alcohol and substance use among adolescents range from low self-esteem to suicide. Violence against adolescents is also rampant and is far worse than in other large metropolitan areas: the homicide rate among teens aged 15 – 19 in LA County is twice that of New York City. *(See the attached LAC Data fact sheets; Section 5: Adolescents).*

E. Assessment of MCH capacity

1. *Summary description of local MCH program capacity.*

a. Monitor local health status: The Los Angeles County MCAH program has a highly developed capacity to assess the health status of populations through its Research, Evaluation, and Planning (REP) Unit. For example, the REP unit updates LA County perinatal statistics on a yearly basis using FHOP templates, and makes these available to the public via our MCAH website. In addition, every five years the REP team analyzes a wide array of MCAH health indicators and creates summary sheets for these health issues as part of the MCAH 5-year-plan needs assessment, collaborating with other health entities to procure high quality data. As a result of these efforts, MCAH is seen by outside organizations as a source for health-related data, and frequently responds to both internal and external data requests. These include the creation of GIS maps that assist MCAH and its community partners in monitoring health indicators across disparate geographic sub-regions. Because the county is so large, monitoring the health status of each of the eight geographic sub-regions represents a substantial challenge.

b. Diagnose and investigate MCH problems: The MCAH Research, Evaluation, and Planning unit is staffed by experienced epidemiologists and research analysts with substantial expertise in the manipulation of data and the use of methodologies for the investigation of MCH problems. For example, the unit is implementing the Perinatal Periods Of Risk (PPOR) methodology to engage community stakeholders in a process involving the analysis of fetal-infant mortality by birth weight and time of death, assessment of the most appropriate types and time periods for intervention, and planning actions to ameliorate disparities. The use of this methodology is not an abstract question: the MCAH program is currently conducting an investigation using PPOR in the Antelope Valley – one of eight geographic sub-regions in the county – for which the latest data indicate an abnormally high rate of infant mortality among African Americans: more than five times that of the county as a whole. Responding to this

critical situation is demonstrating the ability of MCAH staff to handle complex, multi-layered issues. The REP team is also involved in high quality research efforts. The unit recently submitted a proposal for funding for a research project called the Los Angeles Mommy and Baby (LAMB) study. Using a mail survey of newly delivered mothers as well as abstracts of birth records, the study will evaluate the effectiveness of prenatal care on reducing adverse outcomes by measuring utilization, content, and satisfaction.

c. Inform, educate, and empower people: MCAH dedicates significant resources to informing, educating and empowering people in the community regarding MCAH issues. All of our programs – from our health insurance outreach and enrollment efforts to our home visiting programs – include a health education and health promotion component. Contractors providing services through the Black Infant Health program, for example, use a social support and empowerment model that promotes health education in a group setting. The Childhood Lead Poisoning Prevention Program has a health education unit dedicated to reducing the risk of lead poisoning in high risk communities, conducting presentations at community venues and creating culturally appropriate health education materials for distribution. In addition to health education, MCAH also plays an important convening role, facilitating collaboration around MCAH issues. For example, MCAH participates actively in the Los Angeles Best Babies Collaborative, a group of five partner agencies striving to improve birth outcomes in LA County using a comprehensive, community driven, multi-level, and evidence-based approach. MCAH also convenes a quarterly coalition of asthma providers, helping to create and distribute materials for a marketing/educational "Fresh Air" campaign that advocates for appropriate asthma management for children with asthma. With over 100 languages spoken in LA County, MCAH programs always faces the challenge of reaching the county's many culturally diverse communities in culturally appropriate ways.

d. Mobilize community partnerships to solve MCH problems: MCAH is dedicated to community collaboration and approaches all of its work through the lens of inclusiveness, regularly reaching out to its community partners, other Public Health Programs, and other DHS representatives. A recent example of community collaboration includes the MCAH response to the problem of high infant mortality rates in the Antelope Valley (described in 1b above). Upon learning of the problem, MCAH began to collaborate with community representatives in the region, as well as other Public Health officials, to investigate the cause of infant deaths and assist in making recommendations to the Board of Supervisors as to how to address the problem. Other examples of mobilizing effective community partnerships include the MCAH asthma coalition, monthly meetings with contracted agencies involved in MCAH health coverage and Black Infant Health programs, and MCAH's work with the Los Angeles Best Babies Collaborative. A serious challenge associated with mobilizing partnerships in LA County includes the distance partners must travel to attend meetings; Antelope Valley, for example, is 60 miles from downtown Los Angeles, a 1 ½ hour trip.

e. Develop policies and plans that support MCH related health efforts: Through its Children's Health Initiatives unit, MCAH is collaborating with the First 5 Commission, health plans, advocacy groups, providers, and foundations to create universal access to health coverage for children 0 – 18 in Los Angeles County. Through this policy partnership, the Healthy Kids initiative was developed to provide health coverage to children 0 – 5 who did not qualify for

other publicly-funded coverage. These efforts were then expanded to include undocumented children 6 – 18, a group previously without a source of coverage. As a result of these policy efforts, as of June 2004 all children in the county are eligible for free or low-cost health coverage. MCAH has been involved in other policy issues as well. For example, in 2002, MCAH was integrally involved in the Board of Supervisors' Task Force on Youth Physical Fitness, helping to craft recommendations to address the obesity epidemic in LA County, and currently co-leads the Physical Activity and Nutrition Task Force, which is implementing these recommendations. MCAH is currently helping to make LA County a leader in promoting worksite wellness. As of June 2004, MCAH has spearheaded the opening of three lactation rooms for County employees and is piloting an employee worksite wellness program.

f. Link women and children to needed health and social services: Many MCAH programs link women and children to health coverage and help them to access needed services. Through the Children's Health Outreach Initiatives unit, MCAH contracted agencies enroll children and their families into Medi-Cal, Healthy Families, Healthy Kids, and other low-or no-cost health coverage programs. An MCAH representative sits on the Advisory Board of First 5 LA Connect, a telephone information and referral service in which trained specialists pregnancy and child development issues with parents and find them the help they need. In the Nurse Family Partnership and Prenatal Care Guidance programs, public health nurses provide home visitation services to pregnant women before and after the child is born, providing ongoing assessment, referral, and case management to assist clients in gaining access to services. Through the Black Infant Health program, MCAH contracts with community-based agencies that use community health outreach workers to provide culturally appropriate outreach, education, referrals, and follow up for prenatal, post-partum and well-baby care. Unfortunately, MCAH's capacity to conduct this work has suffered in the recent period, as funding has been reduced for many programs and has been lost altogether for others. In addition to funding issues, challenges for MCAH include the need to coordinate better among its programs, so that referrals from one MCAH program to another are seamless.

g. Evaluate the effectiveness, accessibility, and quality of MCH population-based services: MCAH has made great strides recently in its ability to evaluate the effectiveness of program services. Beginning in 2001, the Program initiated an evaluation platform project with two overarching goals: 1) to identify performance measures for each unit so that they would be able to assess the impact of their efforts, and 2) to identify headline performance measures for MCAH as a whole so that the collective impact of the Program could be assessed. The results of this two-year project included forty performance measures for MCAH programs, with nine headline performance measures for MCAH as a whole. Concurrently, a "best practices" data committee was established to share effective data collection practices among MCAH programs. These include the launch in 2003 of an internet-based data system used by all health coverage outreach and enrollment contractors. This system has allowed for the creation of outcome measures for the project, rather than relying wholly on process measures. For example, the data system is able to calculate the percentage of health insurance applications submitted by contracting agencies for which enrollment has actually been verified, as well as the percentage of clients who remain enrolled after one year. Challenges associated with MCAH program evaluation include the need to train grass-roots contractors in data collection methods.

2. *Assess the cultural competency of the MCAH program.*

MCAH is greatly concerned about cultural competency of our services, administrative systems, staff, and working environment. Strengths, challenges, and opportunities faced by the program include but are not limited to the following:

Strengths:

- MCAH conducts high quality data analysis to identify racial and ethnic disparities in health status and access to care. During the needs assessment phase of the 5-yearning process, for example, data analysis was conducted for each health issue under consideration to highlight race/ethnic and geographic disparities. The existence of disparities was chosen by the Planning Group as one of five criteria for selecting the top health MCAH needs for the county.
- Two MCAH programs contract with community based agencies to provide care coordination and health insurance enrollment services to the community: the Black Infant Health Program and the Health Coverage Outreach and Enrollment project. For each of these programs, the ability to provide culturally competent services was a required component of the Request for Proposals, and agencies were selected, in part, based upon their demonstrated ability to provide culturally and linguistically appropriate services. As part of the ongoing monitoring of these projects, contract monitors assess the language and cultural backgrounds of current staff to ensure the continued cultural competency of the agency.
- All DHS employees, including MCAH staff, are required to attend cultural diversity and sexual harassment trainings. In addition, supervisors and managers are encouraged to attend additional trainings on these topics to review regulations and identify management responsibilities in addressing equal employment/affirmative action issues.
- DHS has issued cultural competency standards for all programs and clinics and will be working to implement them in 2004-2005.
- The racial/ethnic composition of MCAH staff is highly diverse, with staff representing many of the cultural and linguistic communities in Los Angeles County.

Challenges:

- In Los Angeles County over 100 languages are spoken, with at least 10 of these spoken by sufficient numbers that they are considered to be "threshold languages". Given the great cultural and linguistic diversity in the County, cultural competence is not something that can be achieved; rather, it represents an ongoing goal and challenge for MCAH.
- Recruiting bilingual, bicultural staff to meet the needs of clients can be difficult given the great demand for such employees in Los Angeles. This is especially true for hard-to-recruit positions. Nursing shortages, for example, make it difficult to recruit public health nurses that are also fluent in another language.

Opportunities:

- Collaborating with community stakeholders is an essential component of cultural competence. One of MCAH's strengths lies is in recognizing that some of the best experts in cultural competence can be found among our community partners.

- MCAH holds quarterly staff meetings to educate and update staff on current MCAH issues and to plan for efficient and effective program operations. At these meetings, staff feedback on program operations is solicited; suggestions for improvement have included issues pertaining to the program's cultural competency, such as the need for staff training on the cultural barriers to breastfeeding, as well as staff training on youth terminology and culture. Responding to staff suggestions for program improvements such as these represents both a challenge and an opportunity, given reduced fiscal resources, increased workloads, and pressure to focus on priority assignments.

3. *Briefly describe current issues in the public and/or private health care sector that impact MCAH program roles*.

Current issues impacting MCAH include but are not limited to the following:

- California State budget cuts: The proposed cuts in the Medi-Cal reimbursement rate are likely to have a serious impact on MCAH clients. Fee reductions for Medi-Cal providers will reduce the number of available Medi-Cal providers in the County, increasing health care access problems for Medi-Cal recipients.
- Los Angeles County Department of Health Services budget deficit: Los Angeles County DHS has a growing budget deficit; solutions for dealing with this fiscal problem could impact MCAH clients in the future.
- Reduced funding from other sources: Until recently, for example, the Nurse Family Partnership and Prenatal Care Guidance programs received significant funding from First 5 LA; this funding has been lost and replacement funds have not yet been identified. As a result, the programs are operating on a skeletal basis, serving very few clients until further funding can be identified.

F. Identification of the Problems/Unmet Needs of the Local MCH Population

Summary of Health Needs:

- Large numbers of adults and children live in poverty, with low-paying jobs and escalating housing prices contributing to the situation
- While the percentage of people with health insurance has increased significantly, Latino children ages 1 to 10 and Latino and Asian/Pacific Islander children 11 to 18 are most likely to lack health coverage
- Rates for low birthweight and premature births are below (worse than) Healthy People 2010 objectives and marked by strong disparities by SPA and race/ethnicity
- Evidence-based clinical guidelines indicate that all pregnant women should be screened for tobacco, substance use, domestic violence, maternal depression, and poor nutrition. However, it is unknown how often these guidelines are followed.
- Prevalence of childhood asthma is high, with disparities by SPA and race/ethnicity for both prevalence of asthma and hospitalization rates for asthma
- Overweight and at-risk for overweight among children (5^{th} and 7^{th} graders) and adolescents (9^{th} graders) is high, with children having a higher rate than adolescents. Los Angeles County is far below (worse than) the Healthy People 2010 objectives for overweight prevalence. Food insecurity is also common, with 22% of lower income households in the county reporting limited access to adequate food. Research indicates

that obesity and food insecurity are related: a higher percentage of respondents living in lower income, food insecure households are obese (27%) compared to those living in lower income, food secure households (20%).

- Adolescents suffer from high rates of depression, substance use and violence. Homicide is a leading cause of death among adolescents and is significantly higher among Latinos than other racial/ethnic groups. The homicide rate for adolescents is twice as high in LA County as in New York City.

Summary of Gaps in Services

- Need to improve the network of provider referrals so that adequate referral resources are available; for example, increase the number of residential substance abuse treatment programs that serve women with children.
- Providers need to be educated about the need to treat asthma as a chronic disease, and the importance of a written asthma management plan to facilitate appropriate asthma care, education, and communication with asthma patients, as well as referrals to specialists as needed.
- A multi-faceted response to childhood overweight is required to address the multiple causes of this problem: improve school nutrition and increase school-based physical activity, improve families' access to healthy, affordable foods, increase the availability of safe, close places for physical activity, advocate for land use policies that promote more physical activity and less driving.
- The demand for alcohol and drug treatment services for youth in Los Angeles County far exceeds the current availability of resources to meet those needs
- Need to increase the number of providers participating in Family PACT (California's Family Planning, Access, Care and Treatment program), which provides access to family planning services for low-income adolescents
- Encouraging providers to adopt nationally recognized professional guidelines for adolescent health care that incorporate youth development and peer education strategies

V. PRIORITY MCH PROBLEMS/NEEDS IN THE JURISDICTION

A. Final List of Priority Problems to be Addressed in Los Angeles County's MCAH 5 Year Plan

1. Women & Infants: Improve Birth Outcomes

Develop strategies that address:

a. Mental health/behavioral health
   - *Domestic violence*
   - *Maternal substance abuse*
   - *Depression*
   - *Stress*

b. Low birthweight, high birthweight, and pre-term births

c. Health coverage
   - Access to quality pre-conception, interconception, and perinatal care

2. **Children: Reduce Asthma**

Develop strategies that address:
a. Childhood asthma
b. Health coverage and access to quality care

3. Children and Adolescents: Reduce Overweight

Develop strategies that address:
a. Overweight
b. Health coverage and access to quality care

4. Adolescents: Promote the Health and Well-being of Adolescents

Develop strategies that address:
a. Violence
b. Substance abuse
c. Mental health

B. Description of Process

The Planning Group and MCAH staff applied the five selection criteria to the health issues presented in Section IV: C & D above. After averaging the results from these two groups, a total averaged score was derived for each health issue. MCAH's goal was to identify the top one to two issues in each of the three population areas: Women & Infants, Children and Adolescents.

In the case of "Women & Infants", the top issues prioritized were: 1). birth outcomes (low birthweight, high birthweight and prematurity); 2). Health coverage/perinatal care; 3). Mental health/behavorial health; 4) Environmental toxins; and 5). Breastfeeding. MCAH decided to combine the top three issues into one interconnected issue, described above.

The top issues prioritized for "Children" were: 1) Asthma; 2) Overweight/obesity; 3) Health coverage; 4) Developmental delays. MCAH decided to address the top two issues, asthma and overweight/obesity, weaving health coverage into the strategies of both issues.

For "Adolescents" the top issues prioritized were: 1) Violence; 2) Overweight/obesity; 3). Substance abuse; 4) Mental health; and 5) Teen birth rate. MCAH decided to combine adolescent overweight/obesity with childhood overweight/obesity into one "need." Violence, substance abuse and mental health were folded together into "health and well-being of adolescents" explained above.

VI. PRELIMINARY PROBLEM ANALYSIS FOR A LOCAL PRIORITY PROBLEM

A. Preliminary Problem Analysis for Overweight

1. Brief Statement of the Problem: The problem of child and adolescent overweight/obesity was prioritized by the Planning Group as a top health need for these populations, based on data analysis indicating that:

- The prevalence of overweight among children (5th and 7th graders) and adolescents (9th graders) is high
- LAC is below (worse than) the Healthy People 2010 objectives for overweight prevalence
- Racial disparities exist for prevalence rates, with Latino and African American children and adolescents most affected
- Low rates of physical fitness for children and adolescents, with Latino and African American children and adolescents having the lowest fitness rates
- Low rates of physical activity among adolescents, with 11th and 12th grade students exercising less than 9th and 10th grade students
- Low rates of fruit and vegetable consumption, with LAC below (worse than) the Healthy People 2010 objectives, and African American children and adolescents having the lowest consumption rates

Preliminary Problem Analysis Diagram:

Individual Level/Primary Precursors include:
- Diet
- Exercise
- Genetic predisposition/medical conditions

Family-Institutional Level/Secondary Precursors include:
- Availability of safe parks and affordable places to exercise
- Access to healthy foods
- Unsafe neighborhoods that make walking/exercise dangerous
- Schools: presence of junk food, availability of nutritional food and amount of physical education available
- Family dietary and physical activity habits
- Access to health services and education to prevent and treat overweight

Societal Policy Level/Tertiary Precursors include:
- Discrimination & distribution of resources (affects where affordable markets and safe parks are located)
- Poverty (affects people's ability to buy healthy food, join gyms, sports teams)
- Unemployment/underemployment (affects amount of time families have to cook, exercise)
- Education (affects employment options, knowledge about healthy eating and exercise, etc.)
- Limited availability of health services/cost of health care

2. List of additional data/information the group identified: The Planning Group spent significant time during the planning process analyzing data related to the list of potential health issues. Part of this process included requests by Planning Group members for additional data on particular health issues. The Research, Evaluation, and Planning unit was able to fulfill many such requests, resulting in improved and additional fact sheets for many health issues. However, for some requests, no adequate source of data was identified. For example, for the health issue of overweight, additional data was requested on the percentage of children in LA County with Type 2 diabetes, however no adequate data source for the prevalence of this disease in children was identified.